College of Pharmacists of British Columbia

APPLICATION FOR PHARMACY CLOSURE

Form 4A

PART 1: Complete Part 1 and submit to the College no later than 30 days before the closure date or by the deadline specified by the College.

1. INFORMATION OF CLOSING PHARMACY

Operating Name			**Pharmacy Licence Number**
Pharmacy Address		**City**	**Province** BC / **Postal Code**
Email Address	**Phone Number**	**Fax Number**	**Closing Date** MMM | DD | YYYY

Reason for Closure: ☐ Permanent closure ☐ Pharmacy licence cancelled ☐ Pharmacy licence expires

PHARMACY MANAGER

Will you be returning any drugs to the manufacturer/wholesaler prior to the closure date?

☐ No, I will transfer all the drugs to the receiving pharmacy named below.

☐ Yes, I will provide the College with the documents described in section 18(2)(ee)(iii) of the *PODSA* Bylaws on/before the closure date.

☐ I have read and understand my duties and responsibilities for closing my pharmacy as described in section 18(2)(ee) of the *PODSA* Bylaws and PPP-65.

Manager Name	**Registration Number**	**Signature**	**Date** MMM | DD | YYYY

DIRECT OWNER

☐ I have read and understand my duties and responsibilities for closing my pharmacy as described in section 18(7)(d) of the *PODSA* Bylaws.

Name of Authorized Representative (AR)	**Signature**	**Date** MMM | DD | YYYY

2. INFORMATION OF RECEIVING PHARMACY*

Operating Name		**Pharmacy Licence Number**
Pharmacy Address	**City**	**Province** BC / **Postal Code**
Phone Number	**Manager Name**	

Items that will be transferred to the receiving pharmacy

☐ Prescription drugs (including controlled drug substances)
☐ Non-prescription drugs (including exempted codeine products)
☐ Medical devices
☐ Patient medication records and prescription records

*If more than one receiving pharmacy is involved, complete a separate form for each receiving pharmacy to indicate the items that will be transferred to the receiving pharmacy.

Part 2: The receiving pharmacy must complete the section below and submit the form to the College within 2 weeks upon receipt of the items.

3. CONFIRMATION OF RECEIPT OF ITEMS FROM THE CLOSING PHARMACY

☐ I have received all the items checked above on (received date): _____.

Manager Name	**Registration Number**	**Signature**	**Date** MMM | DD | YYYY